

WISCONSIN MEDICAID

RURAL HEALTH CLINIC QUARTERLY COST REPORT

REPORTING PERIOD	Date from	Date to
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RURAL HEALTH CLINIC INFORMATION

Name — Rural Health Clinic (RHC)	RHC Group Billing Number	Phone Number	Fax Number
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QUARTERLY SETTLEMENT DETERMINATION

1. Medicaid rate per encounter (apply the rate used on the most recently audited cost report submitted to Wisconsin Medicaid).		
2. Number of Medicaid encounters submitted to Wisconsin Medicaid or Medicaid HMOs for which payment was received. [Refer to clinic records.]		
3. Maximum reimbursement for Medicaid-only encounters. [Line 1 multiplied by Line 2.]		
4. Less:	a) Fee-for-service payments by Wisconsin Medicaid.	
	b) Payments by Medicaid HMOs.	
	c) Medicare payments.	
	d) Commercial insurance payments.	
	e) Total copayments due from Medicaid recipients.	
5. Quarterly payment due to provider. [Line 3, less Lines 4a through 4e.]		

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF CLINIC

To the best of my knowledge and belief, the information on this worksheet is correct and was prepared from clinic records.

Name — Officer or Administrator of Clinic (please print)	Telephone Number
SIGNATURE — Officer or Administrator of Clinic	Date Signed